Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Sudbury Service Area Office
159 Cedar Street, Suite 403
Sudbury ON P3E 6A5
Telephone: 1-800-663-6965
SudburySAO.moh@ontario.ca

Original Public Report

Report Issue Date August 8, 2022
Inspection Number 2022_1472_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Extendicare (Canada) Inc.

Long-Term Care Home and City
Extendicare Timmins, Timmins, ON

Lead Inspector
Karen Hill (704609)

Inspector Digital Signature
Karen L Hill Digitally signed by Karen L Hill Date: 2022.08.16 14:44:50 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): July 4-8, and 11, 2022.

The following intake(s) were inspected:

- One intake of a complaint related to an allegation of staff to resident abuse,
- One intake of a complaint related to an allegation of resident neglect,
- One intake related to resident-to-resident physical abuse,
- One intake related to an allegation of staff to resident abuse,
- Three intakes related to an injury that caused a significant change in health status.

The following **Inspection Protocols** were used during this inspection:

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Responsive Behaviours
- Safe and Secure Home

INSPECTION RESULTS

NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC#001 remedied pursuant to FLTCA, 2021, s. 154(2)

FLTCA, 2021 s. 184(3)

The licensee has failed to ensure that every operational or policy directive that applies to the long-term care home related to COVID-19 active screening for all persons entering the home, was complied with.

Rationale and Summary
The Minister's Directive: COVID-19 response measures for long-term care homes, identified that homes must ensure COVID-19 screening requirements as set out in the "COVID-19 Guidance Document for Long-Term Care Homes in Ontario", were followed.

The "Ministry of Health COVID-19 Screening Tool for Long-term Care Homes and Retirement Homes", identified, at a minimum, the questions that needed to be asked when actively screening individuals who enter the home.

On the first and second day of the inspection, the screener did not ask all the required COVID-19 screening questions during the screening process, before allowing the inspector to enter the home.

The Administrator and Director of Care (DOC) acknowledged that all person's entering the home should be asked all the questions on the screening tool and immediately provided education to the screener regarding proper screening for COVID-19.

There was no impact and low risk to the residents, when the home did not ask all the required COVID-19 screening questions as the home's screening tool included all the required questions for screening and, the home was conducting COVID-19 surveillance testing prior to allowing any person to enter the home.

Sources: Observations; Minister's Directive: COVID-19 response measures for long-term care homes, effective April 27, 2022; COVID-19 Guidance Document for Long-Term Care Homes in Ontario, updated June 28, 2022; Ministry of Health COVID-19 Screening Tool for Long-term Care Homes and Retirement Homes - version 12., dated June 17, 2022; the home's screening tool; and interviews with the screener, the DOC, and Administrator.

Date Remedy Implemented: July 6, 2022 [704609]

NC#002 remedied pursuant to FLTCA, 2021, s. 154(2)

O. Reg. 246/22 s. 97

The licensee has failed to ensure that all hazardous substances at the home were properly labelled at all times.

Rationale and Summary
At the time of the inspection, three unlabelled bottles containing cleaning products were observed in a housekeeper's cart.

The housekeeper and the Housekeeping Manager both indicated that all bottles with cleaning products in them were to be labelled at all times.

After speaking with the Inspector, the home immediately ensured that all bottles containing cleaning products were labelled; revised the Housekeeping Aide Duties to include the responsibility for labelling; and arranged for training for housekeeping staff related to the use and labelling of cleaning products in the home.

There was no impact and low risk to the residents, at the time of the non-compliance, when the home did not ensure that all hazardous products were labelled.

Sources: Observations; review of material safety data sheets; the home's Housekeeping Aide duties; and interviews with a housekeeper, and the Housekeeping Manager.

Date Remedy Implemented: July 11, 2022 [704609]

WRITTEN NOTIFICATION: GENERAL REQUIREMENTS FOR PROGRAMS

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10, s. 30 (2)

The licensee has failed to ensure that the assessment taken in response to a resident's fall was documented.

Rationale and Summary
A resident fell and required further assessment by the Registered Nurse (RN) in charge.

A review of the resident's health record revealed no documentation by the RN.

The Registered staff all verified that the RN in charge completed an assessment of the resident and that the assessment should have been documented in the resident's health record.

There was low impact and low risk to the resident when the RN in charge did not document their assessment made in response to the resident's fall.

Sources: Critical Incident (CI) report; review of a resident's health record; and interviews with a RPN, and RNs.

[704609]

WRITTEN NOTIFICATION: PLAN OF CARE

NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that the plan of care for a resident was reviewed and revised when the resident's care needs changed, specific to falls prevention.

Rationale and Summary
A resident fell and sustained an injury.

The resident's health record was reviewed, which identified the resident had prior multiple falls, and that no new falls prevention strategies were previously added to the resident's care plan related to the ongoing falls.

Staff members indicated that additional falls prevention strategies were implemented for the resident however they were not added to the care plan. Management verified that the care plan should have been updated when the resident's care needs had changed.

There was minor impact to the resident and moderate risk when the home did not review or revise the care plan when the resident's care needs had changed.

Sources: Review of a resident's health records; the licensee's policy titled, "Fall Prevention and Management Program", last reviewed January 2022; and interviews with staff members and the DOC.

[704609]

COMPLIANCE ORDER CO#001 - PLAN OF CARE

NC#005 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: LTCHA, 2007, s. 6 (7) and FLTCA, 2021, s. 6 (7)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with LTCHA, 2007, s. 6 (7) and FLTCA, 2021, s. 6 (7)

The licensee shall:

1. Develop an auditing tool to determine if the falls prevention interventions are in place for residents, as per their plan of care. The audit tool must identify, but is not limited to, falls prevention safety interventions.

2. Assign an individual/s to complete audits at a minimum, three times a week, on all shifts, for at least one month, post the compliance due date to ensure sustainability. The audits must include, at a minimum, whether the falls prevention safety interventions were in place as designed for residents at the time of the audit, and any corrective actions taken. Records are to be maintained of the audits and are to be made available to an Inspector upon request.

3. Develop and implement a documented process to include clear direction to staff on how to use the falls prevention safety interventions used by the home.

4. Ensure all direct care staff and registered staff review the home's processes related to falls prevention and management interventions, including the falls prevention safety interventions. A record of the reviews must be kept and include names, dates, and content reviewed.

Grounds

1. Non-compliance with: LTCHA, 2007 s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

Rationale and Summary

A resident's care plan, for the focus of falls, indicated the resident was to have a falls prevention intervention in place for safety.

On two separate identified dates, the resident sustained unwitnessed fall incidents and the safety intervention was not in place.

Staff and management acknowledged that the safety intervention was not always in place; and that it was the responsibility of the staff to ensure that it was, as outlined in the resident's care plan.

There was low impact and moderate risk to the resident by not ensuring the falls prevention safety intervention was in place. When the intervention was not always in place, the staff were unable to potentially prevent the falls.

Sources: A resident's health record; the licensee's policy titled, "Fall Prevention and Management Program", last reviewed January 2022; and interviews with staff and management.

[704609]

2. Non-compliance with: FLTCA, 2021 s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

Rationale and Summary
A resident's care plan, for the focus of falls, indicated the resident was to have a fall intervention in place for safety.

The resident sustained an unwitnessed fall incident, and the safety intervention was not in place.

The staff indicated that they were not always sure how to use the safety intervention, had not received recent training, and did not know where to locate information to assist them.

Staff and management acknowledged that the safety intervention was not in place at the time of the fall incident and that it was the responsibility of the staff to ensure that it was, as outlined in the resident's care plan.

There was high impact and moderate risk to the resident when the home did not ensure that the falls prevention safety intervention was in place and that all staff knew how to address any issues that occurred. When the intervention was not always in place, the staff were unable to potentially prevent the fall, which resulted in significant injury to the resident.

Sources: A resident's health care record; home's investigation notes; the licensee's policy titled, "Fall Prevention and Management Program", last reviewed January 2022; and interviews with staff and management.

[704609]

This order must be complied with by September 16, 2022

COMPLIANCE ORDER CO#002 - POLICIES AND RECORDS

NC#006 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 79/10, s. 49 (1) under the Long-Term Care Homes Act, 2007 and s. 54 (1) of the O. Reg. 246/22 under the FLTCA, 2021.

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with O. Reg. 79/10 s. 49 (1) and O. Reg. 246/22 s. 54 (1)

The licensee shall:

1. Provide training to two PSWs and one RPN on the home's processes for post fall management and the actions required of the staff.

2. Maintain a record of the training, including names of the attendees, dates attended, content of the training, and the individual responsible for overseeing that the process is completed in its entirety. The training records must be made available to an Inspector upon request.

3. Implement an auditing system to ensure that post fall management as outlined in the licensee's Falls Prevention and Management Program, is implemented, and documented. A copy of these audits must be kept in the home that is accurate and complete for at least one month post the compliance due date to ensure sustainability.

4. Implement and evaluate any corrective actions required to address any identified deficiencies during the audits while ensuring that corrections are incorporated into the quality improvement processes of the home and that these improvements are documented.

Grounds

1. Non-compliance with: O. Reg. 79/10, s. 49 (1)

The licensee has failed to comply with monitoring and documenting at the specified times for two residents.

Rationale and Summary
In accordance with O. Reg 79/10, s. 8 (1) (b), the licensee must ensure that the falls prevention and management program, at a minimum, provided strategies to monitor residents; and must be complied with.

Specifically, staff did not comply with the licensee's policy which indicated that all residents were to be assessed and monitored using a specified document according to the home's established protocol.

a) A resident had sustained multiple falls within a six-month period; a specified document was initiated but was not always completed according to the home's protocol for the falls that the resident sustained.

Additionally, on a specified date, the resident had another fall incident and had a significant change in their condition. The required assessment and specified document were not initiated according to the home's protocol for the fall that the resident sustained.

b) Another resident had multiple falls within a seven-month period; a specified document was initiated but was not always completed according to the home's protocol for the falls that the resident sustained.

Two registered nursing staff and the DOC indicated that staff were expected to initiate and document the required monitoring on the specified document as outlined in the home's policy.

Failing to ensure that the specified monitoring and document were completed as required for two residents, had low impact and placed the residents at moderate risk by delaying the identification of changes in their condition and the implementation of additional care interventions as needed.

Sources: Review of two resident's health records and specified documents; the licensee's policy titled, "Fall Prevention and Management Program", last reviewed January 2022; and interviews with registered nursing staff, and the DOC.

[704609]

2. Non-compliance with: O. Reg. 246/22, s. 54 (1)

1. The licensee has failed to comply with monitoring and documenting at the specified times for two residents.

Rationale and Summary
In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee must ensure that the falls prevention and management program, at a minimum, provided strategies to monitor residents; and must be complied with.

Specifically, staff did not comply with the licensee's policy which indicated that all residents were to be assessed and monitored using a specified document according to the home's established protocol.

a) On a specified date, a resident had sustained an unwitnessed fall; a specified document was initiated but not completed according to the home's protocol for the fall that the resident sustained.

b) Another resident had multiple falls within a four-month period; a specified document was initiated but was not always completed according to the home's protocol for the falls that the resident sustained.

A registered nursing staff and the DOC indicated that staff were expected to initiate and document the required monitoring on the specified document as outlined in the home's policy.

Failing to ensure that the specified monitoring and document were completed as required placed the two residents at moderate risk that a change in their condition may not have been identified, and that the support they needed, may not have been provided. There was a low impact to one resident and a high impact to another resident, who sustained an injury which resulted in a significant change in their condition.

Sources: Review of two resident's health records and specified documents; CI report; the home's investigation notes; the licensee's policy titled, "Fall Prevention and Management Program", last reviewed January 2022; and interviews with a registered nursing staff, and the DOC.

[704609]

2. The licensee has failed to comply with the post fall management care for a resident.

Rationale and Summary

Specifically, the staff had not complied with the licensee's policy, which indicated that the post fall management of residents included observing and reporting any changes in a resident's condition to the registered nursing staff.

A resident had sustained an unwitnessed fall which required monitoring; the resident had a change in their condition.

A PSW indicated that they had observed a change in the resident's condition but had delayed reporting the changes to the registered nursing staff.

A registered staff member verified that the home's expectation was to report changes to a nurse right away.

There was high risk and high impact to the resident when the changes in their condition were not immediately reported to the registered nursing staff, as it delayed the assessment and interventions that the resident required.

Sources: Complaint intake; a resident's health record; CI report; the home's investigation notes; the licensee's policy titled, "Fall Prevention and Management Program", last reviewed January 2022; and interviews with a PSW, and registered nursing staff.

[704609]

This order must be complied with by September 16, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include,

(a) the portions of the order or AMP in respect of which the review is requested. Please include the inspection report # and the order or AMP #;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West,9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.